Personnel Cabinet
Department of Employee Insurance
Flexible Benefits Branch
501 High Street – State Office Building
Frankfort, KY 40601

Refund Request

FSA/HRA Contribution Overpayment

Employee Name:	
Social Security Number:	
Amount:	
Pay Period:	
Plan Year:	
Company Number:	
Reason for Refund:	

Make Check Payable to:	
Return Check to:	
Address:	

I, _____, will distribute the above refund(s) and will adjust the employee's payroll records accordingly.

Date: _____ Signature: _____